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ABSTRACT

The purpose of this study was to gather information about the different types of home visiting services provided to families of at-risk children, with a special emphasis on the home visiting option within the Head Start program. A 13-page questionnaire was sent to 4,162 organizations nationwide that operated home visiting programs. Responses were received from 1,904 of these organizations. The questionnaire surveyed 12 areas: (1) program affiliation; (2) population served; (3) child and parent characteristics; (4) purposes of the program; (5) coordination of services; (6) funding; (7) specific services provided; (8) delivery models for home visits; (9) curriculum for home visiting services; (10) home visitor employment and training; (11) supervision of home visitors; and (12) evaluation strategies. Survey results indicated that 304 programs identified themselves as being associated with Head Start. Compared to other home visiting programs affiliated with health, educational, and social services, Head Start home visiting options possessed a more focused intervention strategy and were more focused on the population they served, the services they saw as important, and the providers of those services. Head Start home visiting options exhibited problems in the areas of efficacy, training, and coordination. Contains 16 references. (MDM)

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Home Visiting Options Within Head Start: Results of a National Survey

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The recent emphasis on community-based, coordinated, family-centered programs for children at risk for health, educational, and social problems (Koop, 1987) suggests the need for a much closer look at home visiting programs as one mechanism to provide for a growing population of children who are eligible to receive services under the new Public Law 99-457 and expanded Head Start programs.

Home visiting services involve a consistent contact outside the center, usually in the client's home between the family of a child and the representative of a formal agency for the purposes of providing help to that family. Home visiting as a procedure to deliver services to families with young children has a long history within the health, education, and social service traditions of Western Europe and the United States (Datta & Wasik, 1988; Miller, 1987; Wasik, Bryant, & Lyons, 1990). However, relatively little information exists concerning the types of programs which now serve children and their families in the home, the client population served, the program objectives, and the qualifications of those providing home visiting services.

Since one of the primary emphases in community-based, family-centered program development is an effort to utilize existing

structures within communities and to build upon programs which are currently in place, it is important to understand current home visiting services and the range of options communities have developed to this point. Some programs are in place because of national initiatives, while others are the result of community and state programs. At the national level, the Administration for Children, Youth, and Families has sponsored a home visiting option within Head Start for some time (Love, Nauta, Coelen, Hewett, & Ruopp, 1976). The Ford Foundation's sponsorship of Child Survival/Fair Start has served low-income families from a number of cultural and ethnic groups across the country (Halpern & Larner, 1988). Within health programs, public health nurses have used home visiting as a procedure to serve a wide range of children and families. Within educational models, home visiting has been used in university affiliated programs such as Project CARE (Wasik, Ramey, Bryant, & Sparling, in press), the Infant Health and Development Program (Infant Health and Development Program, 1989), and the Kupulani Project (Roberts, 1988a).

Some studies suggest that home visiting programs can have a positive effect on developmental outcomes of children and families. Several reviews of the literature have found consistent, though small, positive effects on home-based early intervention for children who are either deemed at risk through poverty or other psychosocial factors. Many programs begin as early in pregnancy or infancy as possible and follow a psycho-educational model of intervention (Gray & Wandersman, 1980;

Halpern, 1984); others have a health focus (e.g., Olds, 1988). Ramey, Bryant, and Suarez (1986) suggest that home visiting alone to families of environmentally at-risk children is not very effective unless paired with a center-based or medical intervention program. Meta-analyses and individual reviews of studies have generally reported weak but positive effects of home visiting services in measures of cognitive gain with young children (Casto & Mastropieri, 1986; Roberts, Wasik, Casto, & Ramey, 1991). Relatively few studies exist which concentrate on the efficacy of home visiting with the Head Start Program.

The dearth of information with respect to the types of home visiting services provided to families and the need for more complete information with respect to the manner in which the home visiting option within Head Start is operated in the field are the reasons for this study. Differences between Head Start and other home visiting programs as a function of the characteristics of children served, the services provided, and the qualifications of home visitors are particularly important to understand.

METHOD

As part of a larger national study of home visiting programs, those which were Head Start Home Visiting programs were compared to those from other health, education or social service affiliations. Information was gathered through a survey instrument described below. A complete description of the survey instrument and the methodology for data collection in the larger sample is included in Roberts and Wasik (1989).

Development of the Survey Instrument

A 430-variable, 13-page questionnaire was developed by the authors that surveyed the following 12 areas:

1. Program affiliation
2. Population served
3. Child and parent characteristics
4. Purposes of the program for parents and children
5. Coordination of services for free-standing and combined programs
6. Funding
7. Specific home visiting services provided
8. Delivery models for home visits
9. Curriculum for home visiting services
10. Home visitor employment and training
11. Supervision of home visitors
12. Evaluation strategies

Each area was clearly labelled and followed by one to seven questions for that area, consisting of both open-ended and forced-choice questions. Most questions required the respondent to either rank-order or select one of several possible answers that best described their program. The questionnaire consisted of 54 separate questions of which 15 were open-ended. Open-ended questions were, in a large part, follow-up questions to allow the respondent to elaborate on or clarify information provided through forced-choice questions.

As an example of a forced-choice response, the question which asked programs to identify their purposes for serving children was worded as follows:

> "Please rank-order all purposes of home visiting listed below as they relate to the children in your program:"
>
> _____ Child cognitive development
>
> _____ Physical development
>
> _____ Social-emotional development
>
> _____ Other

Open-ended questions provided more qualitative information. For example, "combined" programs were asked the following:

> If home visiting is offered in combination with another program, describe the relationship between the programs in a sentence or two, commenting on goals, curriculum, and staff.

Program Identification

A mailing list of 4,162 potential home visiting programs serving children prenatal to 18 was created using several methods: (a) peer nomination, (b) existing mailing lists, (c) nomination by sponsoring agencies, and (d) self-nomination. The following represents a partial listing of organizations whose mailing lists were part of the sample: State Divisions of Maternal and Child Health, Special Education and Social Services, Head Start programs employing a home-based option, as well as the mailing list for Partnerships for Progress One (the National Meeting of Programs and Agencies Involved in Public Law 99-457). The mailing list was screened for duplications and obviously inappropriate programs.

Questionnaires were sent to 4,162 programs which constituted the final mailing list. Seven months after the initial mailing, a follow-up mailing was sent to all nonrespondents in the initial round. Included in this mailing was a checklist for programs to return if they were unable to complete the questionnaire.

The first mailing yielded 1,492 valid responses for analysis; the follow-up yielded an additional 412 valid questionnaires, for a total valid return of 1,904 questionnaires. Thus, 46% of the questionnaires from the initial mailing were included in the final analysis. Questionnaires were collected from January to November 1988.

In the larger national survey, programs were asked to check one of seven categories which best described their program affiliation: Programs could choose from private and public education, health or social service affiliations as well as Head Start. Within this breakdown, 16% of the sample identified themselves as affiliated with Head Start representing 304 programs.

Results

In general, Head Start programs were more likely to serve an older population of children than were other forms of home visiting services. Ninety two percent of the Head Start programs said that they primarily served children in the 3-6 age range. This was consistent with the mission of Head Start as a preschool program primarily designed to serve four year old children. Other programs were more likely to serve children in the birth to three

age range (40%). Twenty five percent of programs in the generic group served children birth to 18 while another 18% serve children in the birth to school range. Clearly Head Start had a narrower focus with respect to the age of children served and that age was older than the modal group for the generic programs.

When programs were asked to identify the primary characteristic of children within their programs, both Head Start and the generic groups suggested that they served a wide variety of children. Thirty six percent of Head Start programs said that the primary child characteristic was that they were from the general population, as compared to 19% of the generic group. Children at risk for school failure was the second highest group for Head Start (28%) compared to 11% for the generic programs. Children who were developmentally delayed were the next most frequently chosen category (24% for Head Start and 25% for generic). Children who were low birth weight, abused or neglected, delinquent, or physically handicapped were much more likely to be identified as priority areas for the generic programs than for Head Start.

Parent Characteristics

By far, the parent characteristic identified as highest in the Head Start programs was that of low income (92%), a finding that was very consistent with the Head Start mission. By contrast there was no clear discernible pattern in the generic group of programs suggesting the full range of parent characteristics in the target groups for these programs.

Purpose

Programs were asked to identify the primary purpose in visiting the families for the children and for the parents. Head Start programs identified social/emotional development of the child as their primary concern in 55% of the programs followed by child cognitive development in another 27%. In the generic programs, no clear consensus of child purpose was discerned. Programs were much more evenly divided among the four potential categories to the point that 25% of the programs in the generic group did not select one of the three primary choices (health cognitive of social/emotional) and chose the fourth category, other, writing in that all were equally important. With respect to the purposes for home visiting the parents, both groups of programs identified parenting skills as their primary purpose for visiting parents (Head Start 63%, generic 42%). In both cases, general parent support was seen as the second most likely purpose (Head Start, 36%; generic, 25%).

Services provided

Programs were asked to indicate those services they saw as having primary importance in their work with families as well as those they did not provide at all. They were provided with a list of 20 potential services from which to make a judgment. Head Start programs were more focused with respect to the services they viewed as of primary importance. They identified nutritional care, (34%) stress management (25%) and enhancement of parent child interactions as most important. These data are particularly

interesting in light of the identification of social emotional development as their primary purpose for the children rather than physical development.

Generic programs displayed less consensus. Still the primary services ranked as most important included enhanced parenting skills (25%), stress management (24%), health care for children (17%). Since each category was individually ranked, all services has an equal opportunity to be ranked as having primary importance.

Coordination of Services

Head Start programs were somewhat more likely to be freestanding programs than were the generic ones (83% vs 70%). Only about half of the Head Start and the generic programs were likely to be involved in P.L. 99-457 within their states.

Management of home visiting services

Head Start programs were much more uniform in the way that home visitor services were reportedly administered than were the generic programs. This was most likely caused by the standardization of services within the Head Start model. For instance 90% of Head Start programs said that they visited families on a weekly schedule as opposed to 45% of the generic programs. A similar pattern could be seen in case load. Sixty five percent of Head Start programs maintained a case load of 11-15 families per home visitor. In general generic programs were more likely to serve fewer families per home visitor that Head Start (66% vs 27% having a case load of 10 or less).

Head Start programs, in general were most likely to serve families for only one year and this was reflected in this survey of home visiting options within Head Start. Three quarters of the programs surveyed said that they saw families for one year versus 18% of the generic programs. An additional 15% of Head Start programs reported visiting families for 1-2 years. No consistent pattern emerged for generic programs. Responses were relatively evenly distributed across all of the options from 1-3 months to over two years.

An important issue within home visiting programs involves the training of home visitors both in preservices and in service programs. Consistent with their mission of being involved in the communities they serve and providing employment within those communities, 90% of Head Start programs have minimal educational requirements below the bachelors level including high school/GED diploma, Child Development associate degree, Associate of Arts degree. In contrast the modal educational requirement for employment in generic programs is the bachelors degree (49%) with less than 25% requiring less than a bachelors degree. It is perhaps for this reason that Head Start is more likely to provide inservices training programs (76% vs 51%). Unfortunately for both groups it is not clear that this training is systematic with written curricula. Two thirds of Head Start programs and three quarters of the generic group said they did not have a written curriculum for training.

Discussion

When compared to health, educational, and social service affiliated home visiting programs, Head Start home visiting options were a more focused intervention strategy. They were more focused on a) the population they serve, b) the purpose for parents and children, c) what services were seen as important and d) who was providing the home visiting services. They appeared to have a clearer philosophy for what they were doing and this philosophy was translated into actual practice as described by the programs themselves.

The troubling components of the Head Start home visiting option involve several areas. Efficacy, training, and coordination. These concerns could be equally applied to generic home visiting in the United States at this point though we will be more concerned with their application to Head Start efforts at this point.

Several recent publications have suggested that home visiting programs may be an effective method for increasing the developmental potential of children at risk for developmental delay. The recent GAO report and the informal review of home visiting programs by Olds and Kitzman (1990) provide evidence for at least some developmental gains for children involved in home visiting programs. The length of these gains and their importance in long term impact on social outcomes for children and families is very unclear. The long and short term efficacies as it applies to home visiting and early intervention is not answered in the way that center based programs have answered that question for at risk

children. It may never be answered in a systematic way because it is very difficult to tease out the effects of a home visiting component from the multitude of services that real families in real programs receive.

Training was a considerable concern in all home visiting programs. Even through training manuals had been developed for Head Start programs, a sizeable portion of those programs reported that they did not have training programs. The high percentage of paraprofessionally trained personnel in Head Start programs accentuated the need for high quality training. In addition, home visitors needed support in ways beyond the technical transmission of knowledge. One way that support could be provided is through an integrated inservice training program. These data did not suggest that this occurred at the rate it was needed.

Finally, the issue of coordination was important. Head Start was known for its interest in being a part of the community that it served. This was reflected in its hiring practices and the in-kind contributions solicited from the community such as space to operate. Given this base, it was surprising that the Head Start programs did not report more coordination of their services with other agencies providing services to children. In part, this may be a function of the stand alone administrative structure established by Head Start where there is not a clear mechanism for them to share information and services with other agencies.

Head Start home visiting programs, then, share some characteristics with other home visiting services. Unfortunately,

we continue to have a very limited knowledge base concerning the efficacy of these programs and the factors within a program which should contribute to the intended outcomes. The interaction of family characteristics, program services and program providers remains an unexplored and unexplicated arena.

Even more importantly, we have few models of which to answer questions concerning factors such as intensity and frequency and what services families actually need rather than those that we are able to provide by what exists now. If we are to create fully family centered programs for at-risk children, these issues must be addressed in the next generation of research.

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